No. 300
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27987

FILED SEP 13 1948

Registration District No. 918

Primary Registration District No. 1003

Registrar's No. 7678

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County
(b) City or town ST. LOUIS (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. ANTHONY HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County 000
(c) City or town ST. LOUIS 17 (If outside city or town limits, write "RURAL")
(d) Street No. 4006 RANDALL 9 (If rural, give location)
15
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME INFANT ROBERT McGUIRE
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M 0
5. Color or race W
6. (a) Single, widowed, married, divorced SINGLE 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased AUG. 30 1948 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
—	—	—	3 hr. — min.

9. Birthplace (City, town, or county) MO. 0 (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name JAMES McGUIRE
13. Birthplace MO 0 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name LORRAINE CHRISTMAN
15. Birthplace MO 0 (City, town, or county) (State or foreign country)
16. (a) Informant JAMES McGUIRE
(b) Address 4006 RANDALL
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 31 1948 (Month) (Day) (Year)
(c) Place: burial or cremation S.S. PETER + PAUL
18. (a) Signature of funeral director Thos Kutis + Son
(b) Address 2906 GRAVOIS
19. (a) AUG 31 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 8 day 30 year 1948 hour 9 minute — P. M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ,
that I last saw him alive on Aug. 30, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Erythroblastosis — Duration: since birth
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Erythroblastosis; enlarged spleen & liver; ascites.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Joseph A. Mueller (M. D. or other) M.D.
Address 3924 So. Grand Date signed 8-31-48

(Licensed Embalmer's Statement on Reverse Side)

2924 So. Grand;
Dr. J. Kneller

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.